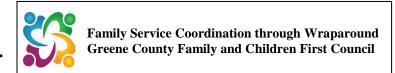
WRAPAROUND REFERRAL



WHAT IS WRAPAROUND?

Wraparound is a free service for Greene County families, who might be experiencing high stress or crisis due to a single event or buildup of multiple challenges. Wraparound is a planning process that helps organize a supportive team around the child and family. Family Voice is at the center of this process because they are the expert on their family. Teams come together to address needs and challenges including: behavioral health struggles, children services contact, developmental delays, medical needs, juvenile justice involvement, psychiatric hospitalizations, problems at school, trauma, and/or youth who need help transitioning to adulthood.

WHO TO REFER?

Greene County Youth ages 0-21 involved with more than one agency and who is willing to participate in developing an individual Family Service Coordination plan through Wraparound.

INSTRUCTIONS FOR REFERRAL

\$

<u>Complete ALL pages and sections of the referral packet</u>. Pages can be filled out by the referral source, the legal guardian, or completed together. *Enrollment Release of Information and Household Income* forms highlighted in yellow MUST be signed by the youth's legal guardian.



Include the following documents with the referral, if applicable:

- Treatment, service and case plans, or court documents for the youth.
- Custody paperwork, if there are designated custody or parenting arrangements.



Email the referral packet to: renee.crossman@greenecountyohio.gov
If assistance is needed with paperwork, please call Renee at: (937) 562-5600.
Wraparound staff will reach out once the referral is received and explain the next steps.



• IMPORTANT: ALL referral paperwork must be filled in and completed in FULL for the next process to begin.

Please share the last page in this packet with the family so that they are aware of the next steps. Thank you!

Greene County Family and Children First

158 E. Main Street Xenia, Ohio 45385 Phone: (937) 562-5600

Fax: (937) 562-5601

QUESTIONS? Contact: Melissa Baughn

Wraparound Coordinator

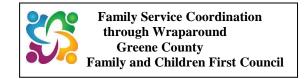
Phone: (937) 562-5607

Email: melissa.baughn@greenecountyohio.gov

Assistance with paperwork: Renee Crossman (Admin)

Email Completed Referral Packet to: renee.crossman@greenecountyohio.gov

ENROLLMENT RELEASE OF INFORMATION FORM



Youth's Full Name:			
Youth's Date of Birth: _			
Caretaker/Legal Guardi	an Name(s):		
Relationship to Youth (son, daughter, grandchild, et	c.):	
I, the undersigned, h	ereby authorize and consent	o: Enroll in the Community Wrapa to the release to share informatio	_
,	First Council, Parent Advocacy		
If applicable Referring	Agency:	Name:	
Phone:	Email:	Length of Involvement:	
Information to be shar	ed may include (but is not li	mited to):	
 □ Name & contact in □ Case Plan docume Records Psycholo Treatment/service information regard □ Wraparound service demographic information 	formation for agencies and in ints: Individualized Education gical Evaluations, School Rec History, Transition Plans, Vo ding the individualized named ces are partially funded by the mation, income-level, and ben	der, race, address, email, and telep dividuals providing services to the Plans (IEP's), Youth/Family Services (attendance, grades, etc.), Sociational Assessments, and other plabove. The Greene County Jobs and Family sefits information) and the Greene information, income & diagnosis	e youth/family. vice Plans, Medical cial History, ertinent personal Services (who requests County Mental Health
this at any time by provid the effective date. Revoc	ing written notice, which includ	form expires upon Wraparound case es guardian name, the name of the yolude any information, which was shaice to revoke.	outh being serviced and
I understand that my signing	or refusing to sign this consent will	not affect public benefits or services for	which I am eligible.
SIGNATURE	DATE	WITNESS	DATE

Re-Release of information beyond that allowed by this consent is not permitted.

Greene County Family and Children First Council: Family Service Coordination through Wraparound Referral Packet Email the completed Referral Packet to FCF Admin: renee.crossman@greenecountyohio.gov

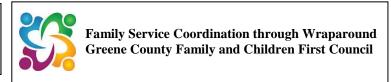
Youth Information fo	or Wrap	aroun	d Ref	erral					
Youth's Name	:		ate of Birth:	Adopt Yes or			School:		Grade:
			-						
Page						Ethni	city		
Race: □ Asian □ Bi-Racial/Mixed R	ass = Diss	l. / A frica	. Amori	II	icnonio	Ethni			
					-		palachian		
□ Native Hawaiian/Pacific Isla□ White or Caucasian	ander un	ative Am	erican /	Alaskan	_ · · · · ·				
	- Non hi	non, / Ot	hor		□ Other: □ Prefer Not to Answer				
Gender: □ Male □ Female Does the youth identify as le									or
								IOL LO ATISW	er
Education: Community Sch						ea 🗆 Ot		1 12 14	
Primary Language: ☐ English	□ Spanisn	□ Ameri	can Sigr	n 🗆 Otn	er:		Interpreter ne	eded? 🗆 Ye	es 🗆 No
Current Placement I	nformat	tion: so	me vou	ıth may r	not he li	ving at ho	me at the time o	f referral d	ie to a stav
in foster care, juvenile deten									
living right now.	tion, psycin	iati ic 1103	pitalizai	tion, trea	itilielit i	acility, et	c. Flease shale w	nere the ye	Julii is
Is the youth out of the home	o currently?) ¬ No ¬	Voc – I	If Voc. nl	2260 COT	nnloto ho	low		
Placement:	currently:		163-1		tact:	iipiete be	iow.		
riacement.				Con	iaci.				
Address:				Pho	ne: ()			
City:	State:	Zip Co	de:	Ema	Email:				
Family Information:	Who m	akes ı	ın the	famil	v?				
Guardian/Parent Name:			.p		-	rent Name	(if applicable):		
Relation:				Rola	tion:				
Marital Status: Date of Birth:				Marital Status: Date of Birth:					
Marital Status. Date of Birth.			IVIGI	Succession Succession					
Address:									
City:	State:	Zip Code:		City	City: State: Zi			Zip Co	de:
Home Phone: ()				Hon	ne Phone	:: (
Cell Phone: ()					Phone:	()			
Employer:					loyer:	, ,			
Work Phone: ()					k Phone:	: ()		
Email:				Ema	il:				
Primary Language:				Prim	nary Lang	guage:			
Interpreter Needed? Yes	No						Yes No		
			I		I .				
Other Household Members	Names:	Date of Birth:	Relation	onship:	Ado	pted?	Schoo	l:	Grade:
					Yes o	or No			
						or No			
						or No			
					Yes o				

If you have additional family members, please attach another page.

Greene County Family and Children First Council: Family Service Coordination through Wraparound Referral Packet Email the completed Referral Packet to FCF Admin: renee.crossman@greenecountyohio.gov

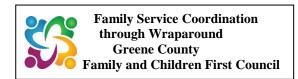
SIE	• •	triend	ds, community member		-		
	NAME:		RELATIONSHIP	PHONE (EXT)	EMAIL ADDRESS:		
			<u> </u>				
He	ealth Information:						
	Mental Health	Provide Primary	Diagnosis:				
	Physical Health	Medical Condition(s):					
	,		(-)				
	Does the youth	Primary Care Doo	ctor's Name:				
_	have a doctor or		Primary Care Doctor's Name:Address:				
	clinic they go to for						
	care? YES NO	Phone Number:					
_		_					
Sy	stems involveme	nt ALL supportir	ng documentation, treatment p	olans, care plans and (Court documents, etc.		
Mι	<u>JST</u> be included in this p	oackage.					
	(Check the box if	the youth is curren	tly involved with these system	s or has a need in the	following areas.		
	Children Services		History of: Abuse I	Neglect			
	Developmental Disab	ilities	Diagnosed Disability:				
			☐ Eligible for DD Services ☐	Has a DD Waiver 🗆	Other:		
	Juvenile Court		Youth has been found: ☐ Unr				
			Is the youth on probation? Yes No				
□ Special Education □ 504 plan □ Evaluation Team Report □ IEP − I				ividual Education Plan			
_	-		□ RTI – Response to Invention	n.			
	Substance Use / Alco	hol & Drugs	Primary diagnosis:				
ш	Substance Ose / Aico	nor & Drugs					
			Substances used:				
	taka and B. W. O. M.			- Ohi- M	-1		
	Jobs and Family Servi	ces	☐ Cash or Food Assistance ☐	Unio Means Job Em	pioyment Programs		
			□ Medicaid				
	Other:						

For Office Use:	
Youth:	
DOB:	
Intake Date: _	



Household Income:				
Full Legal Name (Guardian/Parent or Young A	Adult):			
(First Name)	(Middle Name)		(Last Nam	ie)
Address:				
(Street)				
	Ohio			
(City)			(Zip Code)	
Telephone:				
Complete the chart below for anyone				
Name:	Relationship	Date of	Net Monthly	Income Source*
	to Applicant:	Birth:	Amount of Income:	Write "Work" if from Employment:
1.	SELF		income.	Hom Employment.
2.				
2				
3.				
4.				
5.				
6.				
7.				
8.				
Total Monthly Net Income:				
*Source of Income includes: Work Employment W	<u>l</u> Jages, Adoption Su	bsidy. Alimon	l v. Child Support.	Pension/Retirement
Benefits, Public Assistance, Social Security Income				
Worker's Compensation, Veterans Benefits, etc.	, ,,		, ,	
Check any benefits the family is currently receivi	_			
☐ Cash Assistance/OWF ☐ Food Stamps ☐ If Medicaid, check plan:	Medicaid 🗆 Priva	ite insurance		
□ Buckeye □ CareSource □ Molina □ Param	ount 🗆 United H	ealth Care	Other:	
The signature below affirms that the above infor	mation is true and	d correct.		
(Guardian/Parent or Young Adult's Signature)			Date:	

YOUTH AND FAMILY INFORMATION



1. How did you hear about Wraparound?
2 What do you hope to accomplish?
List the positives / strengths of the youth and family (at school, at home, in community):
List major challenges / needs of the youth and family (at school, at home, in community):
List any major life events the youth / family has experienced:
Other Information you would like to know?